Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

August 2004

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www.hs.state.az.us/bhs

HIPAA Corner… … …

HIPAA Encounter Drug Processing Flow

Encounters will be submitted in HIPAA NCPDP format using the guidelines provided by ADHS/DBHS. The input ENCOUNTER DRUG file name will be hendrgxx.hipaa ("xx" represents the two-digit RBHA number used by DBHS). This file will be sent to the DBHS server, which has individual locations for FTP transfers for each RBHA and a location called RBHA_Common for files that apply to all of the RBHAs. Transactions will be accepted for translation anytime up to the cutoff of 6:00 pm each workday.

During translation processing, any error will result in the complete file being rejected. One file is created and will be named hendrgxx.yyyymmdd.hhmm.bad, which is the original file. This file will be returned to the DBHS server. After translation the accepted file will be named uendrgxx.darbha. This file is used internally by DBHS in the normal daily processing.

There are six files created as a result of the normal daily processing: four of accepted data and one of rejected data; along with the Daily Download Activity Report, which is named ddwnldxx.ctyyyymmdd.nn. All of these files are provided to each RBHA via the DBHS server.

The accepted data file is named dencdxx.dayyyymmdd.nn. After processing, the uendrgxx.darbha file is renamed uendrgxx.dayyyymmdd.nn. In addition to these files, two report files are created for each RBHA, which are named uendrgxx.ctyyyymmdd.nn and h74-enc-rptxx.yyyymmdd.nn.

The rejected data file is named uendrgxx.eryyyymmdd.nn. In the event a RBHA needs to have a file of all Encounters reflected on the DBHS system, which originally were submitted within a particular date range, a "resync" file containing all such Encounters may be requested. The resync file will be named yymmdd ftpxxr42 m.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, Issue Resolution System, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax or mail a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

Third Party Liability (TPL)

To determine if a recipient has third party liability (TPL), use PMMIS and screen RP155. This screen will indicate coverage from a third party administrator. If a carrier listed on this screen, encounters/claims submitted to AHCCCS for dates of service covered must include third party payment information. TPL refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. Third parties include, but not limited to: private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, settlements from any insurer, State worker's compensation, first party probate-estate recoveries, and other Federal programs. The Medicaid program is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an eligible individual. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

If the recipient has third party insurance, the screen will display:

- Carrier Name and Source
- Policy Number
- Coverage Begin and End Date
- Coverage Type
- Change Reason

To view the coverage detail, select the line to view and the following information displays:

- Carrier Name, Number, and Address
- Policy Number and Coverage Type
- Policy Begin and End Date
- Policy Holder's Name and SSN
- Relationship of Policy Holder to Recipient

To return to the previous screen, press F2.

In an ongoing effort to improve the effectiveness of these edits, AHCCCS has a new subcontract to update and maintain its commercial insurance coverage TPL file. An accurate TPL database will assist AHCCCS and its contractors to maximize cost avoidance efforts. The following TPL edits currently on soft will be changed to hard beginning with dates of service October 1, 2004.

The following TPL edits are affected:

- A605 HPP & Other Insurance Amounts > Billed Charge(s)
- H350 Other Pay Amount 1 Not Numeric
- H355 Other Pay Amount 2 Not Numeric
- H620 Other Insurance Indicate Value Y & Other Pay Amount Not Both Present

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Important Reminders . . .

Edit Resolution Document

As discussed at the last ITS Monthly Meeting, the Edit Resolution Document (ERD) has been completed and placed on Sherman in the common area for each T/RBHA to pull down. As new edits are added or the functions of existing edits are changed or updated, a new document will be placed on the server for pick up.

Medicare Coverage

Medicare coverage information must be included for all clients receiving benefits. You should also include coverage for pharmacy items, using Medicare Part D.

Coding Tip

HCPCS code A0110 (Non-emergency transport via intra or interstate carrier) is available to encounter bus passes.

Providers who use this code may find instances where it actually saves money to issue a bus pass to a client instead of encountering bus fare on a daily basis for that client.

AHCCCS Pended Encounter File Processing

AHCCCS started processing the backlog of our "new day" encounters (Oct 2003 – Jan 2004) in the June 2004 cycle. July's cycle included Feb-Mar 2004 and Apr-Jun 2004 encounters are slated for August's cycle. There were several issues with the June & July 2004 cycles. ADHS is working with AHCCCS and the RBHAs to resolve them. The pend file received by the RBHAs in July was a combination of June & July pends.

AHCCCS is allowing more time to clean up pended encounters before they impose sanctions; however, ADHS is encouraging the RBHAs to correct their pends as soon as possible. The Pend_Days and Sanction_Date fields will help you prioritize the cleanup process.

Please remember to send your pend deletions through the daily void process. This will allow the pended encounters to be voided in CIS and deleted at AHCCCS in one step. Only send your pended encounter approved duplicate overrides in the DELDUPyyyymm_rr.TXT file.

If you have any questions, please contact your assigned ADHS Technical Assistant.

Important Definition for Corporate Compliance

Health Care Fraud (18 USC 1347) Prohibits the knowing and willful actions or attempts to execute a scheme to defraud any health care benefit program or to obtain, by means of false or fraudulent pretense, representation, or promises, any of the money or property owned by, or under the custody or control of any health benefit program. Potential penalties include fines and imprisonment for up to 10 years. Imprisonment may be for up to 20 years if the offense causes serious bodily injury and up to life imprisonment if the offense causes death.

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

The following two edits are expected to be implemented for all intakes submitted on or after October 1, 2004:

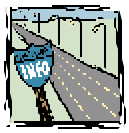
Elimination of Override for SSN & AHCCCS ID on Intakes with no Client ID

The Override submission type will no longer be allowed on intakes submitted with no client ID if the SSN on the new intake matches the SSN on any intake in the CIS database. The RBHA will be required to verify which SSN is correct and either correct the SSN on their intake or arrange to have the RBHA responsible for the intake with the matching SSN correct their intake. Then the new intake may be resubmitted.

The Override submission type will no longer be allowed on intakes submitted with no client ID if the AHCCCS ID on the new intake matches the AHCCCS ID on any intake in the CIS database. The RBHA will be required to verify which AHCCCS ID is correct and either correct the AHCCCS ID on their intake or arrange to have the RBHA responsible for the intake with the matching AHCCCS ID correct their intake. Then the new intake may be resubmitted.

Intake Changes – Edit Exception

On intake CHANGES only: An exception will be added to allow blank Language and Marital Status fields when no Language or Marital Status exists on the original intake because they weren't required fields when the original intake was entered.



Did You Know ???

Reference Files for CIS

CIS Reference files are distributed to each RBHA twice each month. The most current files can be found on the FTP server, these should be downloaded and used to update your files.

Bureau of Financial Operations

The Bureau of Financial Operations provides oversight and coordination of DBHS financial and operational functions to ensure efficient, effective, and accountable operations in accordance with federal and state laws and regulations and Department policies. Functions include fiscal monitoring and budget, provider services, procurement and personnel services. This Bureau has provided leadership in the development of financial standards to assure a healthy balance of the fiscal viability of the system and the needs of the clients it serves.

Billing Questions …

Medicare's "Three-Day Window Rule"

Q An outpatient visit that starts about 8 PM on the 7th and the patient does not go home until 10 AM on the 8th. Then, on the 11th, the patient is admitted with the same principal diagnosis as was on the previous outpatient claim. Obviously, all of the services from the 8th must be combined onto the inpatient bill, but what about the services from the 7th, should they be combined or allowed to remain separately as an outpatient bill since they occurred four days prior to the inpatient admission? How should we handle these scenarios with outpatient claims that span three and four days prior to an inpatient admission?

A One of the most prevalent and costly forms of fraud and abuse is billing Medicare Part B for an outpatient service already paid or payable under Medicare Part A and constitutes the filing of a false claim by the hospital. Short-term acute care facilities under the Prospective Payment System (PPS) cannot separately bill OP diagnostic services provided to a beneficiary within 3 days of admission for IP services that result in an exact match of the diagnosis.

Medicare's "three-day window rule" applies when the beneficiary has Medicare Part A coverage and when the services are provided by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital. The window is 3 days between episodes of care when the principal diagnosis for both the outpatient service and inpatient admission is an exact match. The rule applies from the date of discharge on the first episode of care to the date of admission on the second episode of care.

CMS' *Medicare Claims Processing Manual* specifically states the rule applies to "outpatient bills for diagnostic services with through dates or last date of service that fall on the day of admission or any of the three days immediately prior to admission to a PPS or excluded hospital" (Section 40.3, p. 105).

Outpatient "diagnostic services provided by the admitting hospital to a beneficiary three days prior to the date of admission are deemed to be inpatient services and included in the inpatient payment" (p. 104). To answer your question more directly, the entire charges from the first episode of care must be combined with the account for the subsequent admission because the services are within the three-day window and the diagnosis is an exact match.

CMS has instructed hospitals to implement billing procedures to avoid submission of outpatient claims for diagnostic services considered included in the DRG for the related inpatient admission. A complete study of the three-day window rule is recommended, as the rule is multi-faceted.

The Medicare Claims Processing Manual also contains a list of the diagnostic services defined by the presence of certain revenue codes and/or HCPCS codes that are affected by this rule and provides instruction regarding exempt diagnostic services, such as screening mammograms and renal dialysis.

This question was answered by Diana Spaulding, RHIT, coding consultant at Health Information Management Associates, Inc.

Tip: Use a Layered Approach for HIPAA Security

HIPAA defines "workstation" as an electronic computing device, such as a laptop or desktop computer, or any other device that performs similar functions and stores electronic media. Security experts recommend a layered approach to workstation use and security, including the following:

- **Responsibility** - the authority to use a workstation and rules of behavior associated with it. An organization has full control over the workstations it owns. However, it also has the authority and responsibility for workstations it doesn't own when it comes to accessing and storing ePHI. The authority to connect a workstation the organization does not own to the organization's network for the purpose of gaining access to ePHI should require a formal agreement and rules.
- **Physical layer** - the protection of the workstation itself. For desktop PCs, this would include physical location, positioning, use of screensavers, and protection from theft, such as the use of cable locks, built-in cabinets, etc. For more portable workstations, physical protections include rules for how and where they may be carried, provisions for where they may be kept when not in use, physical identification, and potentially even a tracking mechanism.
- **Access layer** - authentication of a user. Although this is actually a technical safeguard, the nature of the more portable workstations makes it an applicable topic to cover under physical security compliance assurance of workstations. For desktops, in addition to access controls that relate to the privileges each user is authorized to perform and the authentication mechanisms required to prove the user is the person claimed, the physical access layer should also include masking entry of the password and instructions on protection from stealing passwords or access codes by looking over peoples' shoulders as they type.

This article was adapted from the book, ***Guide to HIPAA Auditing: Practical Tools and Tips to Ensure Compliance****.*

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5 Gila River Navajo Nation Pascua Yaqui	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712

AHCCCS
DIVISION OF HEALTH CARE MANAGEMENT
DATA ANALYSIS & RESEARCH UNIT

Encounter File Processing Schedule
August 2004—September 2004

FILE PROCESSING ACTIVITY	August 2004 Sat	Sept. 2004 Sat
Deadline for Corrected Pended Encounter and New Day File Submission to AHCCCS	8/7/2004 5:00 AM	9/4/2004 5:00 AM
Work Days for AHCCCS	6	6
Encounter Pended and Adjudication Files Available to Health Plans.	Tue 8/17/2004	Tue 9/14/2004
Work Days for Health Plans	12	13

NOTE:

1. This schedule is subject to change. If untimely submission of an encounter is caused by an AHCCCS schedule change, a sanction against timeliness error will not be applied.
2. Health Plans are required to correct each pending encounter within 120 days.
3. On deadline days, encounter file(s) must arrive at AHCCCS by 5:00 a.m.

Fraud and Abuse Reporting Protocol

DBHS would like to remind all T/RBHA and provider staff's that any allegations of fraud, waste, or abuse must be referred to the Compliance Officer immediately upon discovery. You may refer any suspected problems directly to the Office of Program Integrity at AHCCCS. DBHS will determine the next course of action for any referred cases. It is also imperative all RBHA employee's, providers, and members, know how and where to report suspicious activity.

In addition to reporting fraud at the RBHA level, anyone who wishes to report a possible incident of fraud, waste, and/or abuse may do so anonymously by contacting either AHCCCS Office of Program Integrity or the Compliance Officer at the Division of Behavioral Health Services.

To contact AHCCCS directly, contact the Director, Office of Program Integrity locally at (602) 417-4045 or *toll free* at 1 (800) 654-8713 ext. 7-4045.

If you prefer, you may write to AHCCCS at:

Director, Office of Program Integrity
801 E. Jefferson, Mail Drop 4500
Phoenix, AZ 85034

Or online at:
https://scertsrv.ahcccs.state.az.us/secureforms/fraudabuse/complain.htm

To reach the Compliance Officer at DBHS, contact Stacy K. Mobbs locally at (602) 364-4708 or (602) 364-3758, *toll free* at 1 (866) 569-4927, or by e-mail at smobbs@hs.state.az.us.

If you prefer, you may write to us at:

Stacy K. Mobbs, Compliance Officer
Arizona Department of Health Services/BHS
150 N. 18th Avenue, 2nd Floor
Phoenix, Arizona 85007